No. 96-110

In the Supreme Court of the United States

OCTOBER TERM, 1996

WASHINGTON, ET AL., PETITIONERS

v.

HAROLD GLUCKSBERG, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether a state statute that makes it unlawful to aid a person to attempt suicide violates the Due Process Clause insofar as it prohibits a physician from prescribing lethal doses of medication for use by competent, terminally ill persons who request the medication for the purpose of ending their lives.

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INTEREST OF THE UNITED STATES

This case raises the question whether a State may prohibit a physician from prescribing lethal dosages of medication for competent, terminally ill adults who request such medication for the purpose of ending their lives. In holding that the State does not have a sufficient interest to justify such a prohibition, the court of appeals relied on the fact that the State permits terminally ill adults to refuse life-sustaining treatment. Pet. App. A82.

The United States owns and operates numerous health care facilities which permit patients to refuse life-sustaining treatment, but do not permit physicians to assist patients in committing suicide by providing lethal dosages of medication. The Department of Veterans Affairs (VA),

which operates 173 medical centers, 126 nursing homes, and 55 in-patient hospices, has a policy manual that generally permits the withholding and withdrawal of life-sustaining medical treatment in response to a patient's request. In contrast, the manual forbids "the active hastening of the moment of death." Department of Veterans Affairs, Manual M-2, ¶ 31.08(c) (Nov. 1991). Similarly, the VA's hospice program guide states that "[t]he hospice philosophy does not condone nor participate in any action intended to hasten * * * the patient's death." Department of Veteran Affairs, Veterans Health Admin., Program Guide 1140.10: Hospice Program ¶ 1.02(b) (Sept. 1996). The military services, which operate 124 medical centers, the Indian Health Service, which operates 43 hospitals, and the National Institutes of Health, which operate a clinical center, follow a similar practice which is not embodied in writing.

In addition, Pub. L. No. 101-508, § 4206(a)(2), 104 Stat. 1388-115, requires all health care providers receiving Medicaid or Medicare, first, to inform all competent adults about state laws concerning the right of patients to refuse life-sustaining treatment and, second, to record any advance directives the patient might have. 42 U.S.C. 1395cc(f). No federal law, however, either authorizes or accommodates physician assisted suicide. The United States therefore has a substantial interest in the resolution of the question presented in this case.

STATEMENT

1. Under Washington law, a person is guilty of a criminal offense "when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code § 9A.36.060(1) (1994). A violation of that prohibition constitutes a felony punishable by imprisonment for as long as five years and a fine of up to $10,000. *Id.* §§ 9A.36.060(2), 9A.20.020(1)(c).

Four physicians who treat terminally ill patients, three terminally ill persons (all of whom have since died), and an organization that provides assistance to terminally ill persons filed suit in the United States District Court for the Western District of Washington against the State of Washington and its Attorney General challenging the State's prohibition against assisted suicide. Pet. App. A10. In their complaint, plaintiffs alleged that "[t]he Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." *Id.* at A17 n.7. Plaintiffs sought a declaration that the prohibition against assisted suicide violates the Due Process Clause to the extent that it interferes with the exercise of that asserted right. *Id.* at A17-A18. Plaintiffs also sought a declaration that the Washington statute violates the Equal Protection Clause insofar as it draws a distinction between terminally ill patients who seek lethal doses of medication and terminally ill patients who refuse life-sustaining treatment. *Id.* at A18.

At the time of the filing of the complaint, each of the patient plaintiffs was mentally competent and terminally ill, each was experiencing severe pain or suffering, and each had made a voluntary decision to hasten his or her death by seeking lethal doses of medication. Pet. App. E3-E4. Jane Roe, a doctor, was suffering from cancer that had metastasized throughout her body; she was bedridden; she experienced constant pain which became especially sharp and severe when she moved; medication could not fully alleviate her pain; and she suffered from swollen legs, bed sores, poor appetite, nausea, vomiting, impaired vision,

incontinence of bowel, and general weakness. *Id.* at E3. John Doe, an artist, was dying of AIDS; he had already suffered twice from pneumonia; he had severe skin and sinus infections; he suffered from grand mal seizures and extreme fatigue; and he was destined to lose all of his vision. *Id.* at E3-E4. James Poe, a retired sales representative, suffered from emphysema; his condition caused him a constant sensation of suffocating; he was connected to an oxygen tank at all times; he regularly took morphine to calm the panic reaction associated with his feeling of suffocation; and he suffered from severe leg pain. *Id.* at E4. Based on their professional judgments, the four physician plaintiffs all believe that they should prescribe life-ending medication for competent, terminally ill patients who request such medication for the purpose of hastening their deaths. *Id.* at E7. They have been deterred from doing so, however, by the statutory prohibition against assisted suicide. *Ibid.*

On cross-motions for summary judgment, the district court ruled in plaintiffs' favor. Pet. App. E1-E29. The court held that the prohibition against assisted suicide unduly burdens the Fourteenth Amendment right of competent, terminally ill persons to hasten their deaths. *Id.* at E28-E29. The court also held that the prohibition violates the Equal Protection Clause insofar as it distinguishes between terminally ill patients who seek to end their lives through lethal doses of medication and terminally ill patients who seek to end their lives by refusing life-sustaining treatment. *Id.* at E29.

2. a. A divided court of appeals panel reversed. Pet. App. D1-D27. Judge Noonan, joined by Judge O'Scannlain, concluded that the prohibition against assisted suicide does not violate either the Due Process Clause or the Equal Protection Clause. *Id.* at D11-D20. The majority concluded that there is no liberty interest in obtaining

assistance for suicide, that the prohibition against assisted suicide is justified by several legitimate state interests, including the State's interest in preserving life, and that the distinction between assisted suicide and the refusal of life-sustaining treatment is not irrational. *Ibid.* Judge Wright dissented. *Id.* at D20-D27.

b. On rehearing en banc, the court of appeals affirmed the district court's judgment. Pet. App. A1-A164. By an 8-3 vote, the court of appeals held that the prohibition against assisted suicide violates the Due Process Clause of the Fourteenth Amendment "as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths." *Id.* at A19-A20.

The court began its analysis by holding that there is a constitutionally protected "liberty interest in choosing the time and manner of one's death." Pet. App. A21. The court drew that conclusion primarily from this Court's decision in *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992). The court of appeals specifically relied on the statement in *Casey* that "matters[] involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Id.* at 851. The court of appeals reasoned that "[l]ike the decision of whether or not to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.'" Pet. App. A57. The court therefore concluded that "[a] competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent." *Ibid.*

The court of appeals also viewed *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), as persuasive authority for its conclusion that there is a liberty interest in determining the timing of one's death. Pet. App. A62. "[B]y recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water," the court of appeals concluded, *Cruzan* "necessarily recognizes a liberty interest in hastening one's own death." *Ibid.*

Having found a protected liberty interest, the court proceeded to "a balancing test under which * * * the individual's liberty interests [are weighed] against the relevant state interests." Pet. App. A22. After assessing the interests asserted by the State, the court concluded that they do not justify a blanket prohibition against prescribing life-ending medication for use by competent, terminally ill patients. *Id.* at A63-A114.

The court concluded that, although preserving life "is one of the [S]tate's important functions," that interest "is dramatically diminished if the person [the State] seeks to protect is terminally ill * * * and has expressed a wish that he be permitted to die." Pet. App. A72. The court acknowledged that the State has "a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated." *Id.* at A73. The court concluded, however, that the State's interest in preventing such occurrences is diminished in the case of terminally ill patients who wish to die, because "the decision to commit suicide [by such persons] is not senseless, and death does not come too early." *Id.* at A74. Finally, while the court acknowledged that the State has an "important" interest in preventing decisions to end life that result from "undue * * * influence[]" by family

members and physicians, *id.* at A84, the court concluded the State should address that "real" concern through procedural safeguards, rather than through a complete ban on assisted suicide, *id.* at A86-A89, A102-A103. The court concluded that "[b]y adopting appropriate, reasonable, and properly drawn safeguards Washington could ensure that people who choose to have their doctors prescribe lethal doses of medication are truly competent and meet all the requisite standards." *Id.* at A103.

Judge Beezer filed a dissenting opinion. Pet. App. A118-A160. He concluded that mentally competent, terminally ill adults have "an autonomy-based, nonfundamental liberty interest in committing physician-assisted suicide," *id.* at A139, and that the relevant inquiry is therefore whether the State's prohibition against assisted suicide "rationally advances some legitimate governmental purpose," *id.* at A155. Judge Beezer concluded that the Washington statute satisfies that standard because it "rationally advances four legitimate governmental purposes: preserving life, protecting the interests of innocent third parties, preventing suicide and maintaining the ethical integrity of the medical profession." *Id.* at A119. Judges Fernandez and Kleinfeld joined Judge Beezer's opinion, and each also wrote a separate opinion. *Id.* at A160-A164. Judge Fernandez expressed the view that "no one has an even nonfundamental *constitutional right*" to commit suicide. *Id.* at A160. Judge Kleinfeld saw no need "to decide whether suicide is a constitutionally protected right" because Washington "has a rational basis for preventing assisted suicide." *Id.* at A162.

c. The full Ninth Circuit was polled, but declined to rehear the case. Pet. App. C1-C2. Three judges dissented from the order rejecting the request for rehearing en banc by the full court. *Id.* at C2-C26.

SUMMARY OF ARGUMENT

The State's prohibition against assisted suicide does not violate the Due Process Clause.

A. A competent, terminally ill adult has a constitutionally cognizable liberty interest in avoiding the kind of suffering experienced by the plaintiffs in this case. That liberty interest encompasses an interest in avoiding not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily or mental functions in the terminal stage of an illness.

This Court's cases make clear that, when the State itself inflicts severe pain or suffering on someone, a liberty interest is implicated. *Ingraham* v. *Wright*, 430 U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A similar liberty interest is implicated when severe pain or suffering is caused by an illness, but the State compels a person to remain in that condition by prohibiting access to medication that would relieve that pain or suffering. See *Planned Parenthood* v. *Casey*, 505 U.S. 833, 852 (1992).

Although *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), involves a liberty interest of greater magnitude, it supports the conclusion that a liberty interest is at stake in this case. *Cruzan* holds that the core liberty interest in avoiding medical treatment through bodily invasions is implicated even when the treatment is life-sustaining and its withdrawal would likely lead to a person's death. 497 U.S. at 279. By a parity of reasoning, the liberty interest at issue here is still implicated at the point at which avoiding severe pain or suffering and ending life coalesce.

While there is a liberty interest at stake in this case, the court of appeals erred when it equated the right to

choose an abortion with that interest. The right to choose an abortion implicates a constellation of liberty and equality rights of fundamental importance that are not implicated here.

B. Overriding state interests justify the State's decision to ban physicians from prescribing lethal medication. The State has an interest of the highest order in prohibiting its physicians from assisting in the purposeful taking of another person's life. The view that there should be an exception to the State's general policy of protecting life for cases in which a competent, terminally ill adult voluntarily requests life-ending medication strikes a responsive chord in many people. At this point in history, however, a State could responsibly conclude that creating such an exception would endanger persons who are not competent to seek lethal medication, persons whose decision to seek lethal medication is not truly voluntary, or those persons who are not in fact terminally ill. The difficulty that physicians have in determining whether requests for assisted suicide come from patients with treatable pain or depression, the vulnerability of terminally ill patients to subtle influences from physicians, family members, and others, and the continuing possibility that someone can be misdiagnosed as terminally ill all support a State's decision to ban all assisted suicides.

The State's interest is not lessened by the fact that the State permits competent, terminally ill adults to refuse life-saving medical treatment. There is an important and common-sense distinction between withdrawing artificial supports so that a disease will progress to its inevitable end, and providing chemicals to be used to kill someone. The imposition of life-saving medical treatment, which often involves highly invasive equipment and procedures, is also a more serious interference with personal liberty. In addition, the risks involved in honoring a person's re-

quest to refuse treatment are far less extensive than the dangers involved in permitting physicians to prescribe lethal medication. Thus, while there is a constitutional right to refuse treatment that the State cannot override, there is no corresponding constitutional right to obtain access to lethal medication.

The difficulty that the State would have drawing any line that is more reasonable than the current line reinforces that conclusion. Once a State decides to create an exception to its prohibition against assisted suicide, there is no obvious stopping point.

State legislatures undoubtedly have the authority to create the kind of exception to assisted suicide fashioned by the court of appeals. But there is no constitutional basis for imposing that exception on all the States. Because terminal illness potentially affects all Americans—all races, both genders, and every income group—there is every reason to believe that state legislatures will address the urgent issues involved in this case in a fair and impartial way.

ARGUMENT

THE STATE'S PROHIBITION AGAINST ASSISTED SUICIDE DOES NOT VIOLATE THE DUE PROCESS CLAUSE

This case requires the Court to determine the scope of the protection afforded by the Due Process Clause, which provides that no State may "deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV. The Due Process Clause has a substantive as well as a procedural component: it not only imposes procedural safeguards against the arbitrary deprivation of life, liberty, or property, but also "bar[s] certain government actions regardless of the fairness of

the procedures used to implement them." *Daniels* v. *Williams*, 474 U.S. 327, 331 (1986).

The Due Process Clause incorporates most of the rights protected by the Bill of Rights, *Duncan* v. *Louisiana*, 391 U.S. 145, 147-148 (1968), as well as certain common law rights that were protected at the time the Fourteenth Amendment was adopted. See *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261, 269-279 (1990). But "[n]either the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 848 (1992). See *Roe* v. *Wade*, 410 U.S. 113, 152-153 (1973); *Loving* v. *Virginia*, 388 U.S. 1, 12 (1967); *Griswold* v. *Connecticut*, 381 U.S. 479, 481-482 (1965); *Pierce* v. *Society of Sisters*, 268 U.S. 510, 534-535 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-403 (1923). This Court has recently stated that the task of defining the sphere of autonomy and personal dignity encompassed within the meaning of "liberty" ultimately requires a reliance on "reasoned judgment." *Casey*, 505 U.S. at 849.

The recognition of an interest as one encompassed within the meaning of the term "liberty" is a crucial first step in deciding whether a state policy violates substantive due process. The acknowledgement that a particular interest qualifies as a liberty interest for purposes of the Due Process Clause, however, does not invariably lead to the conclusion that the State is powerless to interfere with that interest. The question whether a statutory restriction on "liberty" violates the Constitution must be determined by assessing whether the State has an adequate justification for overriding the liberty interest at issue. The strength of the justification that is required depends upon the nature and character of the liberty

interest. *Cruzan*, 497 U.S. at 279 (liberty interest in refusing medical treatment must be balanced against the relevant state interests); *Williamson* v. *Lee Optical of Ok., Inc.*, 348 U.S. 483, 491 (1955) (state restriction affecting a person's ability to engage in a business must merely be rationally related to a legitimate government purpose); *Reno* v. *Flores*, 507 U.S. 292, 301-302 (1993) (infringement on certain fundamental liberty interests must be narrowly tailored to serve a compelling interest).

A. A Competent, Terminally Ill Adult Has A Liberty Interest In Obtaining Relief From Severe Pain Or Suffering

1. " 'Substantive due process' analysis must begin with a careful description of the asserted right." *Flores*, 507 U.S. at 302. The complaint in this case alleged that "[t]he Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." Pet. App. A17 n.7. We do not agree that this Court's decisions support the conclusion that there is a broad liberty interest in deciding the timing and manner of one's death. The term "liberty" in the Due Process Clause, however, is broad enough to encompass an interest on the part of terminally ill, mentally competent adults in obtaining relief from the kind of suffering experienced by the plaintiffs in this case, which includes not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily and mental functions.

2. This Court's cases leave no doubt that when the State itself inflicts severe pain or suffering on someone, a liberty interest is implicated. *Ingraham* v. *Wright*, 430

U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A liberty interest is also implicated when severe pain or suffering is caused by an illness, but the State compels a person to remain in that condition by prohibiting access to medication that would alleviate that condition. For example, in the absence of a subordinating government interest, a State could not prevent a person in extreme pain from obtaining from a qualified physician a medication demonstrated to be safe and effective in alleviating pain. Similarly, the State could not deny to persons suffering from severe and chronic depression access to safe and effective drugs that would relieve that debilitating condition. When the effect of a state prohibition is to prevent a person from ameliorating severe suffering, the State interferes with a liberty interest protected by the Due Process Clause. See *Casey*, 505 U.S. at 852 (among many other things, a prohibition on abortion interferes with a woman's liberty interest in avoiding potential physical and mental suffering associated with unwanted pregnancy and government-compelled childbirth).

3. *Cruzan* supports the conclusion that a liberty interest is at stake in this case. In *Cruzan*, the Court addressed the question whether the term "liberty" includes an interest in refusing medical treatment, even when the treatment is life-sustaining and its withdrawal would likely lead to a person's death. The Court noted that its prior decisions had established that a competent person has a liberty interest in refusing medical treatment, and it concluded that "the logic of th[ose] cases * * * would embrace a liberty interest" in refusing "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life." 497 U.S. at 279. The Court added that "[t]he choice between

life and death is a deeply personal decision of obvious and overwhelming finality." *Id.* at 281.

Although this case does not involve a liberty interest of the magnitude of that at stake in *Cruzan*—avoiding invasions of bodily integrity—it nonetheless implicates a significant liberty interest: avoiding severe pain or suffering. The lesson of *Cruzan* is that once such a liberty interest is acknowledged to exist, it persists even at the point at which avoiding severe pain and suffering coalesces with ending life. That "dramatic consequence[]" is taken into account in deciding whether the State's interest outweighs the interference with liberty. 497 U.S. at 279.

4. We disagree with the court of appeals' equation of the right to choose an abortion with the liberty interest at stake in this case. Pet. App. A56-A57. The fundamental right to choose an abortion rests on a combination of constitutionally protected interests, of which avoiding the pain and suffering associated with being forced to continue an unwanted pregnancy is but one part. A prohibition on abortion interferes with personal autonomy in an extremely consequential way: by forcing a woman to continue an unwanted pregnancy, the State requires a woman to undertake the birth of, and responsibility for, another person in a way that has no counterpart in our laws. The decision whether to have a child has life-long spiritual, moral, psychological, and legal consequences for both the woman and any child she may bear. The bearing of an unwanted child is fraught with the potential for "cruelty to the child" and "anguish to the parent." *Casey*, 505 U.S. at 853.

The right to choose an abortion, moreover, stands at the intersection of constitutional liberty and constitutional equality. "Requiring women to bear unwanted children threatens to lock them into a traditional and subordinate role, embodies assumptions about their inability to make

autonomous moral choices, and burdens women as a group with obligations that have no counterpart in the burdens that the State demands from men." Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay On Roe, Casey, And The Right To Die*, 44 Am. U.L. Rev. 803, 849 (1995) (Kreimer). There is therefore a profound equal protection dimension to the right to choose an abortion that is wholly absent here. See *Casey*, 505 U.S. at 852 (stating that a woman's "suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture"); *id.* at 856 ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."). The right to choose an abortion thus implicates the liberty of a woman "in a sense unique to the human condition and so unique to the law." *Id.* at 852.

Because the right to choose an abortion implicates a constellation of liberty and equality rights of fundamental constitutional importance, the court of appeals erred in equating the right at issue in this case with that right. There is nonetheless, for the reasons we have discussed, a liberty interest at stake in this case: a State may not, without adequate justification, prevent a person from obtaining relief from severe suffering.

5. The conclusion that a liberty interest is at stake in this case cannot be avoided by the assertion that terminally ill patients can receive relief from their pain without taking lethal doses of medication. There are some few patients whose pain cannot be alleviated.[1] There is,

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[1] While most terminally ill persons can obtain relief from extreme pain through palliative treatment, studies show that an "irreducible core of patients are trapped in physical agony (if they are awake)."

moreover, suffering beyond physical pain for some in the terminal stages of illness. A patient in the terminal phase of a disease may suffer from several serious conditions that may not be fully treatable, including the constant sensation of suffocation, the inability to sleep, the loss of appetite, and nausea. New York State Task Force Report on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40-41 (1994) (*Task Force Report*); Pet. App. E3-E4. Most important, perhaps, the inability to exercise control over bodily or mental functions can itself be a source of great despair. A constitutionally protected liberty interest is at stake for all these persons.

B. Overriding State Interests Justify The State's Decision To Ban Physicians From Prescribing Lethal Medication

As previously discussed, the question of whether an individual's constitutional rights have been violated must be determined by assessing whether the interests asserted by the State in support of a restriction on liberty override the individual's interest in liberty. In some contexts, a State may justify an interference with liberty by offering no more than a rational and legitimate justification. *Williamson*, 348 U.S. at 491. In other circumstances, the State must show that any restriction is narrowly tailored to further a compelling interest. *Flores*,

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Kreimer, 44 Am. U.L. Rev. at 831 & n.93 (pain can be effectively controlled in up to 90% of all cancer patients); The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 & n.18 (1994) (pain can be effectively controlled in 90%-95% of all cases; in the remaining cases, the reduction of pain would require sedation into a sleep-like state, an option that is considered only in the last days or weeks of a person's life).

507 U.S. at 301-302. And in still other contexts, an intermediate standard is applied in which the individual's "liberty interests" are "balance[d] * * * against the relevant state interests." *Cruzan*, 497 U.S. at 279; *Youngberg* v. *Romeo*, 457 U.S. 307, 321 (1982). For reasons discussed, pp. 24-25, *infra*, there are important differences between the liberty interest in refusing medical treatment recognized in *Cruzan* and the interest in avoiding severe pain or suffering at issue here. Nonetheless, the interest in avoiding the suffering or pain of terminal illness may be sufficiently analogous to the interest in refusing medical treatment to justify the application of the same legal standard for determining whether the State's interests are overriding. Measured by that standard, the state interests supporting the ban on assisted suicide are sufficient to justify the limitation on liberty embodied in that prohibition.

1. The State of Washington does much to accommodate the liberty interest of a competent, terminally ill adult in obtaining relief from severe pain or suffering. The State permits terminally ill, competent adults to refuse unwanted medical treatment when it is offered and to order the withdrawal of such treatment if it has already begun. Wash. Rev. Code §§ 70.122.010-70.122.030 (1994). Equally important, the ethical standards of the medical community have long permitted physicians to prescribe medication in sufficient doses to relieve pain, even when the necessary dose will hasten death. AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* § 2.20 (1989). So long as the physician's intent is to relieve pain, and not to cause death, such treatment does not violate the ethical standards of the medical community. *Ibid.* The question presented in this case is whether the State is constitutionally required to take the additional step of permitting physicians to prescribe lethal medica-

tion for competent, terminally ill adults, when the acknowledged purpose of the prescription is to end the patient's life.

2. As a general matter, the State unquestionably has an interest of the highest order in prohibiting its physicians from assisting in the purposeful taking of another life. "[T]he States—indeed all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280. In addition, the Due Process Clause itself "protects an interest in life" as well as an interest in obtaining relief from pain and suffering. *Id.* at 281. The question is whether the Constitution requires a State to make an exception to its general policy of protecting life in the class of cases in which a competent, terminally ill adult voluntarily requests life-ending medication in order to obtain relief from severe pain or suffering. The case for such an exception strikes a responsive chord in many people.

Responsible and fair-minded legislators, however, must not only concern themselves with the effect that a prohibition against assisted suicide will have on the class of persons identified by the court of appeals. They must also concern themselves with the effects that creating an exception to that prohibition would have on others. One difficult question for lawmakers, including those who believe that the prescription of life-ending medication is defensible in some circumstances, is whether an exception can be created for persons like the plaintiffs in this case without endangering the lives of many other persons who do not satisfy the criteria specified by the court of appeals. The State must attempt to decide, in the face of much uncertainty, whether the creation of an exception to its

prohibition against providing lethal medication for the competent, terminally ill adults who voluntarily request the assistance will lead to the deaths of many persons who are not competent, who are not terminally ill, and who do not make truly voluntary requests for assistance. At this point in our history, there is little doubt that a legislature may responsibly decide that making lethal medication available for some "would create widespread and unjustified risks for many others." *Task Force Report* at 135. A State therefore may conclude that it has an overriding interest in maintaining a prohibition against all assisted suicides.[2]

a. One special source of concern is that terminally ill persons who contemplate suicide often suffer from undiagnosed depression and inadequately treated pain. *Task Force Report* at 126-128. In most cases, once appropriate treatment is provided, the desire for suicide abates. As explained in the *Task Force Report*, "[g]iven access to appropriate relief from pain and other debilitating symptoms, many of those who consider suicide during the course of a terminal illness abandon their desire for a quicker death in favor of a longer life made more tolerable with effective treatment." *Id.* at 120-121.

It is perhaps possible to posit a world in which physicians who treat terminally ill patients could readily distinguish between requests for suicide that stem from treatable depression and pain and requests that are based

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[2] This Court therefore need not decide, in the abstract, whether the State has an overriding interest in protecting the life of a competent, terminally ill adult who makes a voluntary decision to seek lethal medication in order to alleviate severe pain or suffering that is not treatable. That question would have to be decided only if it were clear that creating an exception from the prohibition against assisted suicide for such persons would not lead to the deaths of other persons whom the State has an unquestionable interest in protecting.

on severe pain and suffering that is not treatable. But "the reality of existing medical practice in doctors' offices and hospitals * * * cannot match th[ose] expectations." *Task Force Report* at 120. The truth is that physicians often fail to detect treatable depression in terminally ill patients and that they undermedicate persons in pain. *Id.* at 127-128. Any exception to the ban on assisted suicide therefore runs a very significant risk that persons with treatable depression and pain will be allowed to commit suicide. A State has an overriding interest in avoiding that risk and in protecting persons who would want to remain alive if provided with the appropriate treatment. That interest is directly implicated here, and the State could responsibly conclude that the appropriate way to serve that interest is by continuing to prohibit all assisted suicides.

b. Another area of concern is that terminally ill patients are often extremely vulnerable and susceptible to influence by physicians, family members, and others on whom they depend for support. A terminally ill person may have a strong desire to remain alive. But if that person perceives that those around him disapprove of that choice, it may be difficult to remain steadfast in that choice. The problem is even greater if the patient begins without a strong resolve to cling to life. The point is not that physicians or family members will attempt to coerce persons into committing suicide, although there may be some cases of that. The real dangers are much more subtle and extremely difficult to monitor and address.

For example, physicians may offer lethal medications based on their own judgments concerning the quality of the person's life and their own belief that any rational person in that condition would want assistance in committing suicide. *Task Force Report* at 124-125. Physicians may readily accept a person's request for suicide,

rather than offering emotional support for a decision to remain alive because of their "own frustration in situations when medicine can provide care but not cure." *Id.* at 123. Pressures to cut costs can also affect judgment. When the choice is between suicide and an expensive and prolonged course of treatment, physicians may feel pressured to suggest the former. *Ibid.* "Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy." Kreimer, 44 Am. U.L. Rev. at 841.

Many terminally ill patients are under the care of physicians with whom they have personal relationships, and many of those physicians have the time, energy, and sensitivity to help patients who request assisted suicide in making a truly voluntary decision about their treatment options. Such physicians know that terminally ill patients often voice a desire to commit suicide as a way of seeking confirmation that there is still value to their lives. *Task Force Report* at 128. And when physicians affirm that the patient's life continues to be valued and devote the necessary time to bring that point home, patients often respond with a renewed sense of purpose. *Id.* at 129. In the real world, however, patients do not always receive advice from sensitive and caring physicians. That advice also comes from doctors who are "harried," who are "uncomfortable talking about dying," who are "unable to distinguish their views from the values and needs of their patients," or who are dealing with patients "with whom they have had little contact and for whom they hold no hope of recovery." *Id.* at 130.

The involvement of family members in decisions about a terminally ill relative presents a very different set of concerns. Providing care and support to a terminally ill fam-

ily member can exact an enormous financial and emotional toll. *Task Force Report* at 124. Undertandably, some family members, at some point, may hope that a lingering illness that has left a loved one in a debilitated state will come to a quick end. "Close family members may have a strong feeling—a feeling not at all ignoble or unworthy, but not entirely disinterested, either—that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading." *Cruzan*, 497 U.S. at 286. Even those determined to keep such thoughts to themselves can have difficulty hiding their true feelings from the ones they love. Those who are terminally ill may come to feel that their only real choice is to comply with the unstated wishes of their family members by seeking a lethal prescription. *Task Force Report* at 124.

c. Another difficulty with permitting doctors to prescribe lethal drugs for terminally ill patients is that illnesses can be misdiagnosed as terminal. In fact, "[a] surprising number of people have had the experience of being misinformed that they had a terminal illness." Richard A. Posner, *Aging and Old Age* 245 (1995) (Posner). If the State were to create an exception to its ban on assisted suicide for terminally ill adults, such a misdiagnosis could have tragic consequences. That is particularly true in cases in which lethal medication has been sought by persons only because they were mistakenly informed that they were suffering from a terminal disease. The State has an overwhelmingly strong interest in preventing such tragedies from occurring.

d. The court of appeals acknowledged the State's important interest in protecting the lives of those who do not really wish to die, but who request lethal drugs from their doctors because of real or perceived pressure from others to choose death. Pet. App. A84. The court concluded, however, that the State should address that concern through procedural safeguards. *Id.* at A102-A103. A State is not constitutionally precluded from attempting to deal with the issue of voluntariness through procedural safeguards. But a State could also fairly decide that, in light of the special vulnerability of terminally ill patients and the many subtle ways in which physicians and family members can influence them, a scheme of procedural safeguards would not be effective in ensuring that choices about death are truly voluntary. To prevent the very real danger that persons who want to live will feel unduly pressured to choose death, the State may decline to give its imprimatur to physician assisted suicides through lethal medications.

In gauging the strength of a State's interest in enacting a categorical ban on assisted suicide in order to protect the lives of persons outside the class of persons described by the court of appeals, it is useful to examine the experience of the Netherlands. In that country, doctors are not subject to legal sanctions for assisting suicide where the patient's request is persistent and voluntarily made, where the patient's condition is beyond recovery or amelioration, and where the doctor has consulted with a colleague to ensure that the relevant criteria have been satisfied. Burial and Cremation Act, Stb. § 10 App. (1994); see also Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* 25-44 (1991). All physician assisted deaths must also be reported. Burial and Cremation Act, Stb. § 10 (1994).

A recent study shows that those procedural safeguards have not worked. In 1990, more than one-half of assisted deaths were not even reported. Yale Kamisar, *Against Assisted Suicide—Even A Very Limited Form*, 72 U. Det. L. Rev. 735, 752 (1995) (Kamisar). More troubling, there were 1000 cases in which physicians had taken the

patient's life without having received an explicit request. *Ibid.*

There are dangers in relying too heavily on the experience of another country in predicting what would happen if physician assisted suicide were permitted in this country. But the Netherlands experience is the only test thus far of whether procedural safeguards can adequately protect the State's interest in protecting the lives of those who fall outside the class of persons described by the court of appeals.

3. As we demonstrate more fully in our amicus brief in *Vacco* v. *Quill*, No. 95-1858, the strength of the State's interest in this case is not diminished by the fact that the State permits competent, terminally ill adults to refuse life-saving treatment. There are important distinctions between the two. First, there is a very significant distinction between removing artificial supports—and thereby allowing the underlying disease to progress to its inevitable end—and providing chemicals to kill someone. In one case, the cause of death can reasonably be viewed as the underlying disease; in the other, the cause of death can only be viewed as the lethal medication. That important, common-sense distinction is reflected in the laws of at least 40 states that permit the withdrawal of life-sustaining treatment, but prohibit the prescription of lethal drugs. Compare Pet. App. A68 & n.77 (listing States that permit the withdrawal of life-sustaining treatment) with *id.* at A135-A136 & nn.10-12 (listing States that prohibit assisted suicide). The distinction may not be completely satisfying in all of its applications, but it is entirely logical in the vast majority of cases.

The imposition of life-saving treatment also involves a significantly more serious interference with personal liberty than a prohibition against lethal prescriptions. To force upon an unwilling patient artificial, invasive means

of life-support is not only to transgress the "sacred * * * right of every individual to the possession and control of his own persons," *Cruzan*, 497 U.S. at 269 (quoting *Union Pac. Ry.* v. *Botsford*, 141 U.S. 250, 251 (1891), but to force upon the patient a condition of total physical dependence in which his bodily existence may be literally taken over by machines.

As in the case of physician-provided lethal medications, there are risks that extending a right to refuse life-sustaining treatment to competent, terminally ill persons who voluntarily request it may endanger the lives of persons outside that class. But the risks are significantly less serious in both kind and degree. The prescription of life-ending drugs leaves no opportunity to correct a misdiagnosis of terminal illness. In contrast, when life-sustaining treatment is withdrawn, certain death does not follow if the diagnosis of terminal illness is mistaken. More important, the class of persons at risk of making a decision that is not competent or truly voluntary when a State recognizes a right to refuse treatment is self-limiting: the risk extends only to those who would die without treatment—many of whom are in hospitals or nursing homes. While that is not an insignificant number of people, permitting assisted suicide would extend that risk to a much larger group of persons in circumstances that may be much more difficult to monitor.

Thus, there are constitutionally significant differences between refusing medical treatment and obtaining lethal medication. Accordingly, while competent, terminally ill adults have a constitutional right to refuse life-saving medical treatment that the State may not override, see *Casey*, 505 U.S. at 857, we believe that such persons have no corresponding constitutional right to obtain lethal medication. In the latter context, in our view, a State may decide that its interests are overriding.

4. Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point. Indeed, "[m]ost proposals to legalize assisted suicide have rejected terminal illness as the dividing line because it would not respond to many circumstances that can cause the same degree o[f] pain and suffering." *Task Force Report* at 132. Once the exception is expanded to anyone who suffers from severe pain and suffering, however, it may become difficult to contain effectively. *Ibid.*

Moreover, once a categorical prohibition against prescribing lethal medication to assist suicide is lifted, it may be difficult to justify a categorical prohibition against permitting physicians to administer lethal medication themselves (usually referred to as active euthanasia). When a person experiencing severe pain or suffering requests life-ending medication, but is physically unable to take the medication himself, active euthanasia is the only possible way to satisfy his request. Timothy Quill, a leading advocate of physician assisted suicide and a respondent in the New York case presently before the Court (No. 95-1858), initially opposed active euthanasia on the ground that it created unacceptable risks of abuse not present when the final act is solely the patient's. Kamisar, 72 U. Det. L. Rev. at 747-748. Two years later, however, Dr. Quill changed his mind, arguing that a prohibition against physician administered life-ending medication unfairly discriminates against patients with unrelievable suffering who resolve to end their lives but are physically unable to do so. *Id.* at 748. The court of appeals in this case similarly noted that any distinction between a physician prescribing lethal medication and a physician administering such medication would be difficult to maintain. Pet. App. A100-A101.

The extraordinary difficulty in drawing fully defensible lines in this area is significant. The line between withdrawing life-saving treatment and providing lethal medication may not be fully satisfactory in all of its applications. But it is at least as reasonable as any other line that could be drawn. In such circumstances, there is no basis for a court to invalidate the line drawn by the State.

5. When a State seeks to reconcile the liberty interests of some people with the risk of death to others, it must be given some latitude in drawing the appropriate line. See *Youngberg*, 457 U.S. at 320, 322-323. That is particularly true in this context, where there is every reason to believe that the state legislatures will address the competing interests in an impartial and unbiased way. Posner at 260-261.[3] Terminal illness does not single out any discrete or insular minority; it potentially affects all Americans—all races, both genders, and every income group. All legislators must face the possibility that they will one day suffer from a terminal illness; there are no immunities from that fate. There is, in sum, no constitutional basis for preempting the continuing legislative reexamination of the urgent issues involved in this case.

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[3] States have begun to consider anew the issue of physician assisted suicide, and there is no indication that the political processes are malfunctioning. Voters in the State of Oregon approved a ballot initiative permitting physician assisted suicide in November 1994. Pet. App. A49. Initiatives in California and Washington were rejected, but they were supported by 46% of the voters. *Ibid.* And "[p]roposals to permit physician-assisted suicide have also been introduced in Iowa, Maine, Michigan, and New Hampshire." *Id.* at A49 n.52.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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